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A Narrative Inquiry Into Understanding Female Adolescence and Anorexia Nervosa

by

Karen Maureen Andres ©

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements of the degree of
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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *A Narrative Inquiry Into Understanding Female Adolescence and Anorexia Nervosa* by Karen Maureen Andres in partial fulfillment of the requirements for the degree of Master's of Science in Health Promotion.

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ABSTRACT

The purpose of the study was to collect stories from female adolescents who are experiencing or have experienced anorexia nervosa, to understand why the illness develops. A narrative design was chosen. Three female adolescents aged 13-21 years were interviewed in an open interview format. The participants had to meet the diagnostic criteria, as established by the American Psychiatric Association DSMR IV. The interview were taped and transcribed. Content analysis was used to identify themes that emerged from the findings.

The major findings from the study revealed that low self-esteem was present in all the participants' stories, prior to the onset of anorexia nervosa. The females reported an increase in attention at the start of their weight loss which acted as positive reinforcement for their dieting. All participants had suicidal ideation but only one had a suicide attempt. The results also revealed that two of the participants use self-mutilation.

DEDICATED TO

Katharina Andres
1907-1998

Gramma, without your wisdom, guidance, determination
and example, I would have never made it through.
I will love you, ALWAYS.

PREFACE

This thesis began as a quest to answer some questions about my past, my present, simply about myself. Anorexia Nervosa came into my life at the age of seventeen, during my last year of high school. It came at a point that I believed I felt good about who I was. It crept out of the darkness of issues I had not even recognized that I had, and consumed my life with such force, that my world was changed, from that moment on. I have never regretted struggling with the illness. I do regret, deeply, what it did to members of my family. It did indeed, change my family members as well.

My personal struggle with the illness, made me come to terms with who I was. My first years at University were different than my peers, as I was battling a rage within, that at times, felt stronger than I could handle. My Gramma Andres, told me often of her life through the depression, losing her husband and having to raise three small children. She prayed often and had a very strong faith. I followed her example and utilized my faith. I also increased my faith to incorporate a spirituality beyond Christianity. I set out to become the best person I could be. The person I have become, and continue to evolve into, is a result of my journey with Anorexia Nervosa. It, Anorexia Nervosa, began the journey, that has not ended to this day. I only wish that all those who encounter Anorexia Nervosa, come to terms with why they have the illness, and release it from the stronghold it has on their life. It is an illness that unless one walks in its moccasins, one will never understand, the determination behind the self-starvation. I thank my participants for sharing their stories. Life with Anorexia Nervosa is not an easy story to tell.

I do hope that the content of this thesis brings understanding and enlightenment about Anorexia Nervosa and those that struggle with it. Maybe with more understanding, we, involved withing the health care realm, can educate, and thus prevent individuals from enduring such a struggle, for their life.

Karen Maureen Andres
June 1998

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CHAPTER ONE

Introduction

"The history of the diet industry in America probably represents one of the most astounding triumphs of the twentieth century capitalist enterprise" (Brumberg, 1988, p. 25). In North America, a multi billion dollar industry has launched a widespread preoccupation with weight, dieting and exercise that has escalated to such a degree that it is an accepted, encouraged and rewarded aspect of social life (Brown & Jasper, 1993). For example, commercials, such as the recent advertisements for *Special K* cereal, speak to ideals presented in advertising and the difficulty to meet and/or maintain such standards. The advertisement with a slender young female and a middle aged "pot bellied" man, carries the slogan about the female figure being concerned with her weight. Furthermore, diet centers are consistent with the media but they persist for members to join by promising that members will look and feel better post-weight loss. Consumer products concentrate on marketing "light", "fat-free", "low in fat" items. One researcher, Brumberg (1988) does not adhere to the belief that external forces such as the media contribute exclusively to the genesis of psychopathologies, but he believes that the media influenced the frequency of the genesis of these psychopathologies. However, Rosenberg (1989) reports that the media may influence attitudes to extraneous items, such as a political party but not towards personal selves. What are the ramifications of our culture's obsession with weight and the external presentation of an individual?

One researcher, Killian (1994) estimates the prevalence rate for female adolescents suffering from anorexia nervosa, to be between one to three percent. Researchers such as Shisslak, Crago, & Estes (1995) believe the rates of partial syndromes, those individuals who do not meet all the diagnostic criteria for an eating disorder, to be higher than those individuals who meet the complete criteria. This preoccupation with weight "fat phobia" is affecting our youth with serious consequences. For example, the mortality rate for anorexia nervosa is the highest recorded for mental illness (Tolstoi, 1993). Furthermore, individuals who are untreated for anorexia nervosa risk contributing to a mortality rate of 10-20 percent (Powers, 1996).

Other researchers hold contrasting views. For example, Brumberg (1988) believes culture is to blame for the development of anorexia nervosa. Conversely, Bruch (1985) argues the above position negates the psychological complexity of the illness. Yet Bemporad (1996) would dispute these conclusions; he says it is only when food is plentiful that voluntary starvation can serve a psychological purpose. However, Button (1990) believes low self-esteem to be the main denominator that determines whether an adolescent will just "dabble" in dieting or become more obsessive and develop an eating disorder.

Osborne (1996) cites Zumph and Harter (1989) who state "Adolescents who assume that self-evaluation of appearance determines self-esteem, feel worse about their appearance, are effectively more depressed and exhibit lower self-esteem than those adolescents who assume that self-esteem level determines one's self-evaluation of appearance" (p.25). For the anorexic body,

fatness becomes the criteria by which non-physical attributes are evaluated (Garner & Garfinkel, 1982). Classic research by Erickson (1968) twenty-one years earlier, describes adolescents as "clannish" excluding members with different skin color, culture or even dress. The implication is that one has to be similar to the rest of the "clan", in order to belong.

Alder (1992) found some adolescents already have a sense of inadequacy, a feeling of not being as good as others. Likewise, Rosenberg & Simmons (1975) found that females are socialized to be inferior and thus have lower self-esteem than their male counterparts. Also, there are others who believe, "the impact of parents' behaviors upon the child's self-esteem is undeniable" (Bednar, Wells, Peterson, 1989, p.257). "The crucial factor in terms of self-esteem development is the quality of parent-child relationship" (Sandford & Donovan, 1984, p.30).

With the reported incidence of eating disorders increasing rapidly over the past 20 years (Nagel & Jones, 1992), it is becoming imperative that an understanding as to why eating disorders develop be ascertained. Furthermore, there is no confirmed successful treatment of the disease, to date. "It is relatively easy to restore a malnourished patient to normal weight during hospitalization, but this does not mean a cure has been obtained" (Castiglia, 1989, p.106). To date, there are several different treatment programs listed for eating disorders, however the literature review did not identify a program that reported a successful cure for the disease.

Purpose of the Study

Understanding the reason(s) why anorexia nervosa develops, will help to refocus attention away from treatment and onto prevention. To assist in understanding the reasons behind the illness, consulting those who have personally been affected by the illness is important. Therefore, the purpose of this study is to collect stories of young female adolescents who are experiencing or have experienced anorexia nervosa, to increase the understanding of why the illness develops, as well as the course of the illness itself.

The collection of participants' stories can take many research forms. This study will utilize narrative design to collect and analyze the stories. "Narrative analysis takes as its objects of investigation, the story itself" (Kohler Reissman, 1993, p.1). The use of narrative allows for both the story to be told and the individuals' understanding or meaning of the story to be divulged(Kohler Reissman, 1993). She elaborates further, by stating that difficult life transitions and trauma can be made sense of by the individual in the narrative form(Kohler Reissman, 1993).

Delimitations

This study will only address anorexia nervosa and not other eating disorders. The term eating disorder in the literature, is an umbrella term covering bulimia, bulimia nervosa, and compulsive eating to name a few. Only anorexia nervosa as defined by the Diagnostic and Statistical Manual of Mental Disorders(DSMR) IV manual will be addressed in this study. The

criteria from the manual are listed on page 18 of this thesis.

This research focuses on female adolescents. Although anorexia is not restricted to this aggregate, for the purpose of this study only adolescent anorexics will be invited to participate. Female anorexics were sought from the general public and specifically, elite athletes and professional dancers were not included. They were excluded because the literature identifies the reason for their illness is their desire to excel in their performance area. For example, the decision to diet excessively might be driven by the coach or instructor.

For further clarification, the term family will be used in this study. The term family is meant to represent parent(s). The inclusion of siblings was not considered in this research.

Limitations

The data set provided limitations as there are only 3 subjects interviewed for this study. The stories provided a qualitative foundation for future research; due to the number of participants, the results from this study can not be generalized to the population. The subjects were located via a snowball effect and three people volunteered to participate. The value in the data was that the subjects are either in the midst of their struggle or not far removed from their struggle, in recovery. Their stories increased the understanding of why this illness develops to facilitate interventions and preventive programming using a health promotion perspective.

CHAPTER TWO

Literature Review

The following literature review will define the terms used throughout this study. The chapter begins with historical and contemporary descriptions of adolescence. Next self-esteem will be defined. Self-esteem will also be described within the context of anorexia. Finally, a description of Anorexia nervosa, prevalence rate, diagnostic criteria, historical perspective, and then the contemporary perspective of anorexia nervosa will be presented. Studies are selected from the literature of females, both adolescent and adults, that provide important information that can be utilized in this research and discussed in the following section.

Adolescence

Adolescence is a social phenomenon and is defined according to its cultural norms (Eisenberg, 1965). Further to the cultural explanation, Erickson (1968) describes the adolescent time period as clannish, where those who are different in skin color, culture, and aspects of dress can be excluded from a group. The actual development of adolescents' physical, emotional, social, and spiritual selves, does not always occur in tandem (Pipher, 1994; Rosenberg 1989; Eisberg, 1965). For example, Eisenberg (1965) characterizes adolescence as a stormy period which can be prolonged if the childhood is marked by severe deficits. He believes psychological maturation is dependent

upon "psychological nutrition", which is both cognitive and social stimulation; whereas , Button (1993), believes adolescents experience certain levels of psychological distress. In other research, Pipher (1994) uses the analogy of a toddler moving away from the parent physically which she parallels with the adolescent moving away emotionally. Adolescence is often described as the time period after childhood and before adulthood (Pipher, 1994; Erickson, 1968; Eisenberg, 1965; Bandura, 1969) however, Douvan and Adelson (1965) believe identity formation begins in childhood and that during adolescence a more concrete identity must be formed.

The purpose of this study is to collect stories from female adolescents who are experiencing or have experienced anorexia nervosa. For the purposes of this research adolescence is operationally defined as the time period of growth between 13 and 21 years. This period was chosen by the researcher to provide a spectrum of data.

Self-esteem

There are many terms used in the literature that relate to self-esteem. One of these is self-concept; it is described by Osborne (1996) as the sum total of the attributes, abilities, attitudes that a person believes identify who he or she is. Similarly, self-schemata are cognitive generalizations about the self derived from past experience (Markus, 1977). According to Osborne (1996) self is the integration of self-concept, self-esteem and self-preservation. The different terms are provided to report the potential variations, in the usage of self-esteem.

Researchers, themselves, have variations about the meaning of self-esteem. McKay and Fanning (1992) believe awareness of self differentiates human from animals. Humans have the ability to form an identity and attach a value to it. Similarly, Rosenberg (1967) believes self-esteem directs thought and action of the selection of values, goals, social structure and interpretation of facts, whereas, Osborne (1996) defines self-esteem as a positive or negative feeling about self based on one's capabilities and limits. However, Aleksiuk (1996) associates self-esteem with a sense of competence while Erickson's (1980) concept of self-esteem, is developing a defined personality within a social context that one comprehends. Conversely, Silverstone (1992) defines self-esteem as a sense of contentment and self-acceptance that originates from individuals' appraisal of their own worth. A simple definition by Rosenberg(1989), is most profound and relevant to this study, "Self-esteem is a positive or negative attitude toward a particular object, namely the self" (p.30).

Some researchers believe that the development of self-esteem can be attributed to receiving praise. "Little forms of acknowledgment are essential to developing deeply rooted and lasting self-confidence. Without self-acknowledgment during childhood, an individual does not develop inner strength" (Aleksiuk, 1996, p. 85). Osborne (1996) cites Tomasello (1983) who believes that due to the interaction of those around an infant, at nine months he/she will start to develop a sense of self. "From the start, striving for significant fulfilment becomes the unconscious aim of the child" (Adler, 1992, p.10). As well, Silverstone (1992) concurs that self-esteem development begins

during childhood and increases slowly through adolescence. Cooley expressed most vividly the point that,"our attitudes toward ourselves are importantly influenced by the views others hold of us" (Rosenberg, 1967, p.544). Maslow (1970) concurs with others that a healthy self-esteem is based on respect from others. The developing self-esteem of a child, is rooted in the internalization of beliefs about themselves, communicated by others (Bednar, Wells & Peterson 1989). As well, Markus & Kitayama (1991) and Akridge (1989) believe that significant others are parents and peers. Similarly, Sanford and Donovan (1984) state that "the crucial factor in terms of self-esteem development is the quality of parent-child development" (p.30). The parents' form of child rearing during the first three to four years impacts on the child's development of self-esteem (McKay & Fanning, 1992). Felson & Zielinski, (1989) and Demo et al. (1987) concur by concluding that parents who communicated and participated with their children had children with higher self-esteem. Hoelfer and Harper (1987) also had similar findings. Both Felson & Zielinski (1989) and Gecas & Schwalbe (1986) found the father to have the greatest influence on self-esteem of the adolescent.

The way the family functions has profound implications for individual development (Minuchin, 1978). The effects of inadequate understanding and inconsistent responses to his/her needs lead the child to conclude that he/she is not as good as others, even perhaps flawed in some way. Adler (1992), Bednar et al. (1989) and Bruch (1982) acknowledge that parents may be sensitive to the development of self-esteem but the verbalized concepts should be translated into feelings and experiences by the child. It is within the family

that children develop as autonomous individuals (Minuchin, 1978, p. 52). Adler (1992) and Bryant & Kopeski (1986), in contrast to Felson and Zielinski (1989) and Gecas and Schwalbe (1986), strongly believe it is the child's relationship with the mother that contributes to sense of worth. For example, Adler (1992) notes, "Whenever the mother-child relationship is unsatisfactory we usually find certain social defects in children" (p. 225). McKay and Fanning (1992) state self-esteem is the armor that protects children from the dragons of life (drugs, alcohol, unhealthy relationships and delinquency). Women, whom in childhood, did enjoy unconditional love tend to be more self-confident (Sanford & Donovan, 1984). Satisfaction of self-esteem needs results in feelings of self-confidence and worth (Maslow, 1970). Cooley is careful to emphasize that it is not what others actually think of us, rather it is one's personal interpretation of others' thoughts that is decisive (Rosenberg, 1967). Bandura (1977) believes it is the strength of individuals' convictions that determines how he/she will try to cope. For example, low self-esteem reflects self-rejection, self-dissatisfaction and self-contempt (Rosenberg, 1989). Akridge (1989) agrees stating, "lack of self-esteem results in feelings of inadequacy and inferiority" (p. 29). Rosenberg & Simmons(1975) state "The brunt of the argument is that women are socialized to feel inferior and thus have lower self-esteem" (p. 248). Researchers may have different opinions about the development of self-esteem, however, it is the how the individual copes with the feelings about his or herself that could influence their choices.

Self-Esteem and Anorexia

Low self-esteem is well documented in association with eating disorders (French, Perry, Leon, & Fulkerson, 1995; Button, 1993; Bryant & Kopeski, 1992; Silverstone, 1992; Garner & Garifinkel, 1982). "Adolescents with anorexia nervosa are characterized as having less acceptance, more self-rejecting and self-neglecting" (Fisher et al., 1995, p. 427). "Many anorexics express themselves in similar ways, with much the same imagery, that their whole life had been an ordeal of wanting to live up to the expectation of their families, always fearing they were not good enough in comparison with others and therefore disappointing failures" (Bruch, 1978, p. 23). Garner & Bernis (1985) concur stating, "Within our weight preoccupied culture it is easy to imagine how the female adolescent suffers from feelings of inadequacy, might select weight as a frame of reference for self-evaluation" (p. 129). "By exerting control over their bodies women attempt to gain self-esteem and become in control over their lives" (Brown & Jasper, 1993, p. 17).

Other researchers such as Beaumont et al. (1995) and Garner & Garfinkel (1985), believe self-esteem to be an important factor in adolescent females' vulnerability to an eating disorder. "Dissatisfaction about feeling enslaved and exploited and about not having developed as an individual in their own right, emerges in puberty and adolescence" (Bruch, 1982, p. 1533). "Thus the female adolescent or young adult who has low self-esteem, may be highly prone to turn to weight control, through equating slimness with a greater social success" (Button, 1993, p. 17).

The researchers cited, assist in understanding the influence that self-esteem has in the development of anorexia nervosa. The development of anorexia nervosa is multi-factoral and the literature above highlights the impact self-esteem may have on anorexia nervosa.

Anorexia Nervosa

Prevalence

"The national chapters of Anorexia Nervosa and Related Eating disorders, Inc. and Anorexia Nervosa and Associated Disorders estimate 20% of the total female population between 12 and 30 years suffer from a major eating disorder" (Nagel & Jones, 1992, p. 108). For anorexia nervosa alone, within the adolescent population, the prevalence rate is estimated to be 0.5% (Pipher, 1995; Shisslak et al., 1995; Killian, 1994; Tolstoi, 1993; Akridge, 1989). "Anorexia nervosa has been occurring with increasing frequency during the past 20 years, for reasons that seem to be related to sociological attributes and the changing role of women" (Bruch, 1982, p. 1531; Nagel and Jones 1992; Herzog and Copeland ,1985; and Kagan and Squires, 1984). Morbidity and mortality rates for anorexia nervosa are highest of psychiatric or mental illnesses (Tolstoi, 1993; Akridge, 1989; Herzog & Copeland, 1985). For example, Powers (1996) sites the untreated anorexia mortality rate to be between 10 and 20 percent. These statistics are intended to emphasize the seriousness of the illness. However, "prevalence rates alone are inadequate to assess rates of eating disorders because they reflect only the number of women who have eating disorders in a particular population at a given point and time"

(Biber-Hesse, 1992, p.387). Therefore, with the increasing prevalence of anorexia, it is important to clarify and understand why it develops.

Diagnostic Criteria

Fisher, Golden, Katzman, Kriepe, Rees, Schebendach, Sigman, Ammerman, and Hoberman (1995) describe the four criteria presented in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSMR) IV for a diagnosis of anorexia nervosa. They include the following:

1. Refusal to maintain body weight over a minimal normal weight of age and height; or failure to make explicit weight gain during period of growth, leading to body weight below 15% of that expected.
2. Intense fear of gaining weight or becoming fat even though underweight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation or denial of the seriousness of current low body weight.
4. In post menarcheal females, amenorrhea.

(Fischer et al., 1995, p. 421)

"In the classical description of anorexia nervosa, the emphasis has been mainly on the physical consequences of the undernutrition, severe weight loss, skeleton-like appearance, anemia, dryness of skin, soft fine body hair growth, cessation of menses, low body temperature and low basal metabolism" (Bruch, 1978, p. 7). Bruch (1985) also believes the cultural emphasis on slenderness undermines the psychological complexity of the disorder. Characteristics such as, severe body image disturbances, inaccuracy in identifying body and emotional states, along with a sense of ineffectiveness describe the psychological underpinnings of the disorder (Bruch, 1985). Furthemore, Button (1990) adds that low self-esteem is a critical determinant that decides whether the adolescent goes beyond a relentless flirtation with dieting .

Historical View

Anorexia nervosa is not a recent phenomenon. In 1868, Sir William Withey Gull, prominent London physician described a condition as "hysteria apepsia" (Brumberg, 1988). Five years later, he was convinced anorexia (lack of appetite) was more applicable than apepsia, which means indigestion (Brumberg, 1988). Nervosa was chosen as it implied the central nervous system instead of the uterus (Hysteros) (Brumberg, 1988). "Gull attributed the anorexics alleged lack of appetite to morbid mental state and not to gastric disorder of any kind (Brumberg, 1988, p. 70).

As mentioned above, the history of anorexia nervosa dates back to earlier times; it is captured by Bell (1985) in his book entitled Holy Anorexia. Two years later, Byrum (1987) also published a book entitled Holy Feast and

Holy Fast (Bemporad, 1996). Both works described self-starvation among a large number of European women from the 13th to 17th centuries.

A Contemporary View

Although there is a history of anorexia nervosa, there remains a lack of understanding of why it develops. For example, Brumberg (1988) believes culture is the determinant of the psychopathology of the anorexic adolescent. "The occurrence of these behaviors (re: self-starvation) throughout most of recorded history, should cause us to rethink whether eating disorders are actually a product of current social pressures rather than a deeper mode of self expression adopted by individuals in other epochs and other cultures" (Bemporad, 1996, p. 217). Bemporad (1996) goes on to argue that it is only "when food becomes abundant can voluntary denial of food serve a psychological purpose" (p. 220). Button (1993) does not agree that social factors alone contribute to the development of an eating disorder as only a minority of women suffer with problem eating. In contrast, Brumberg (1988) believes it is the "economic and cultural factors that interact with individual and family characteristics that exacerbates the social and emotional insecurities that put today's young women at increasing risk for anorexia nervosa" (p. 248). Beamont, Russell and Touyz (1995) are unsure if social pressures are a predisposing factor to the development of eating disorders or if those pressures are accentuated as a result of having the illness. Jenkins (1987) concurs with this position. In response to social pressures, the fat phobia has resulted in a billion dollar industry which has contributed to the

increased incidence of eating disorders and wider prevalence of body dissatisfaction, resulting in low self-esteem (Ciliska, 1993).

Some researchers purport that anorexia, per se, is a misnomer (Amara & Cerrato, 1996; Carino & Chmelko, 1983; Bruch, 1982). For example, Tolstoi (1993) and Bruch (1982) believe that anorexia nervosa is a disorder in which an individual refuses to eat. Similarly, Brown (1983) interprets eating behavior as the individual communicating that there is something wrong whereas Carino & Chmelko (1983) suggest anorexia develops as a result of ego deficits. The pursuit toward thinness is discussed as a personal struggle for control. For example, Killian (1994) concurs stating, "Anorexia and bulimia allow women a degree of power in their lives while appearing subordinate to society's expectation" (p.313). The anorexic utilizes body shape as an index by which non-physical characteristics are evaluated (Garner & Garfinkel, 1982). From the above research, the understanding of why anorexia nervosa develops remains diverse amongst the researchers in the field.

Psychological Characteristics of Anorexics

There appears to be some similarity in the emotional make-up of anorexics. Williams et al. (1993) and Casper (1977) found perceived external control, low assertiveness, low self-esteem, and feelings of powerlessness as traits of anorexia clients whereas, Button (1990) discovered girls with low self-esteem to be more fat conscious. Several researchers, French et al. (1995), Fabian and Thompson (1989), Striegel-Moore et al.(1986) and Kagan and Squires (1984) concur. Focusing on expectations, Kagan and Squires (1984)

found the key identifier with adolescents with an eating disorder was that they had failed to meet their expectations and the expectations of others. Streigel-Moore et al. (1986) who emphasized expectations related to self, found those who sought perfectionism in many areas of their lives also focused on aspiring to be thinner than most.

Other Characteristics of Anorexics

In the literature, there are six researchers who have described other characteristics of anorexics, in addition to psychological ones. The following are the researchers with a summary findings from their research. For example, Jenkins (1987) found anorexics to be from upper social class, have high academic standards, and have intact families, however, Thompson, Coovert, Richards, Johnsons, and Cattarin(1995) discovered a history of teasing to be linked to disturbances in eating and body image. The above researchers also found eating disturbance and general psychological function to be reciprocal. Toner et al. (1986) found anorexia to be associated with affective or anxiety disorders, whereas Woodside and Garfinkel (1992) found anorexics to develop their disorder at an older age than bulimics. Research by Biber-Hesse (1992) concluded that there is such a range of eating disorders that some individuals may go undetected, unstudied and untreated. Sadly, Herzog et al. (1992) unveiled that there is no consensus on the treatment of patients with eating disorder.

Impact of the family

There are several studies in the literature that discuss the impact of the family on the development of anorexia nervosa within adolescent female members. Some studies analyzed the characteristics of the families with a daughter suffering from anorexia nervosa. For example, Crisp et al. (1976) found that although the disorder was not confined to the middle class, there was a strong association with it. Speculating, Kalucy et al. (1977) suggested that perhaps the lower social class could not seek psychiatric help and therefore went undetected. A group of researchers examined family dynamics rather than class. They found family dynamics, such as lack of emotional display and strict discipline played a role in the development of anorexia (Reeves & Johnson, 1992; Rastam &Gillberg, 1991; Striegel-Moore & Connor-Greene, 1991; Strober et al., 1985 Kalucy et al., 1977). Similarly, Brumberg (1988) postulated that the prolongation of dependency and the intensity of parental love contribute to the onset of anorexia nervosa in daughters. However, Garfinkel et al. (1983) suggest that while there are family factors present, they are not necessary nor sufficient to cause the disorder. Pursuing a different avenue in their research, Crisp et al. (1974) analyzed psychoneurotic morbidity of the family and parents; they found a relationship with anorexia. Morgan and Russell (1975) concur suggesting a connection between disturbed parent-child relationships and difficult relationships at school with female children with anorexia nervosa. In contrast, Attie and Brooks-Gunn (1989) and Gowers et al. (1985) from their research concur that no stereo typical family structure existed that contributed consistently to the

development of anorexia nervosa in females. However, Friedlander and Siegel (1990) and Crisp et al. (1980) found a correlation between difficult mother-child relationships and anorexic daughters. As well, Gecas and Schwalbe (1986) found girls' self-esteem was affected by parental appraisals.

In summary, the above literature cited implies that the family is not the sole contributor but instead a potential contributor to the development of anorexia. The purpose of this study was to collect stories of young female adolescents who are experiencing or have experienced anorexia nervosa, to understand why the illness develops, as well as the course of the illness. Family relations were considered throughout the investigation as a potential contributor to the anorexia.

CHAPTER 3

Methodology

Narrative Design

For the purposes of this study, a qualitative design was utilized. "Only by listening to what our participants tell us of their experience can we enter into dialogue with their meaning system - and this is the value of narrative forms of investigation" (Josselson, 1995, P. 37). The narrative is an "effort to approach the understanding of lives in context rather than through a prefigured and narrowing lens" (Josselson, 1995, p.32). The purpose of this study was to collect stories of young female adolescents, to further understand how anorexia develops, as well as the course of the illness. Their stories provide the context of their battle with the illness. "Narrative and life go together, and so the principal attraction of narrative, as a method, is its capacity to render life experiences, both personal and social in relevant and meaningful ways" (Connelly and Clandinin, 1990, p. 10).

Miles and Huberman (1994) cite three reasons to use the narrative. Narrative forces the researcher to be less mechanistic, than would be the case in the use of other forms of research. The researcher is compelled to be honest and explicit about casual relations amongst the text. The second reason, is that narrative allows a more thorough explanation of the relationships amongst the variables. The third reason is, to allow for collaboration amongst researchers or colleagues in analyzing the data for casual relations.

Narrative is the means by which we shape our understandings and make sense of them (Josselson, 1995). The use of narrative inquiry allows the

participants to describe their story, as they remember it. "Narrativization tells not only about past actions but how individuals understand those actions, that is , meaning" (Kohler Reiessman. 1993, p. 19). Within this study, the use of narrative provided the framework to allow participants to tell their stories, and share their meanings of their stories. "A narrative is a kind of life story, larger and more sweeping than the short stories that compose it" (Connelly and Clandinin, 1988, p. 24). These researchers also state that narrative is a study of how individuals construct meaning around an experience by telling and retelling stories about themselves. Two of the subjects have told their stories before, as part of their recovery process. This repetition of story telling allows individuals to frame the past and create purpose for the future (Connelly and Clandinin, 1988). Josselson (1995) concurs stating, "when we study whole human beings, we are aiming to interpret others who are themselves engaged in the process of interpreting themselves" (p. 31). Josselson (1995) expands further, stating that narrative provides the perspective of the individual in his or her complexity and recognizes that although some phenomena will be common to all, some will remain unique to the individual. The participants in this study told their stories within a one-to-one interview. It was through the analysis of the stories that similarities and differences appeared. The narrative approach assisted in making sense out of the multitude of perceptions and experiences of life (Josselson, 1995).

The purpose of this study was to collect stories from young female adolescents to assist in understanding why the illness, of anorexia nervosa develops, as well as the course of the illness. The stories that were collected

were read and reread to identify themes and patterns from individual perspectives of the development of anorexia nervosa. By inviting individuals to describe their personal situations, beginning with what they perceived contributed to the development of the illness, without direction from specific interview questions, a more expansive disclosure of the experience was gained.

Sample Size

The sample size was set to be greater than one and no more than five female adolescents who are currently suffering from anorexia nervosa or have recently struggled with the illness. The researcher was unaware of the availability of people for the study. The subjects met the diagnostic criteria of anorexia nervosa as stated by the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSMR) IV (listed on page 13).

The individuals for the study were located by a snowball method through friends and from other anorexics who were contacted. One adolescent female anorexic, who was contacted, was able to provide names of additional potential participants. Three participants were interviewed. The female adolescents who participated between 13-21 years old. The interviews with the participants occurred between December 1997 and February 1998.

Data collection

Data were collected using one-to-one interviews. The interview contained one open ended grande tour question. Additional open ended questions were formulated (located in Appendix A) and were used to prompt participants to remember their development of anorexia nervosa. Interviews lasted about one hour in length; they were taped and transcribed. According to Kohler Riessman (1993), "Taping and transcribing are absolutely essential to narrative analysis" (p.56).

At the beginning of the interview, participants were informed that they could discontinue the interview at any time during its course. No notes were taken during the interview. Note taking has been perceived to make youth feel less comfortable, while discussing personal stories. However, reflective or recall field notes were written after each interview was complete.

The participants, at the end of the interview, were asked if they could be called upon for a follow-up telephone interview after the data were analyzed. The participants were informed that participating in the follow-up interview was also voluntary. The follow-up interview was used to allow the participants to verify their stories. The final document will be made available to the participants as a token of appreciation for their participation.

An audit trail was kept by the researcher during data collection to assist in adding credibility. It is recognized that the audit trail is important for replication of the study. This was kept, along with other data, in a locked and secure location at the researcher's home.

Data Analysis

Data analysis, within the narrative approach, is loosely formulated, almost intuitive, using terms selected by the researcher (Manning and Cullum-Swan, 1994). Furthermore, Kohler Riessman (1993) believes , "Narrative analysis allows for systematic study of personal experience and meaning: how events have been constructed by active subjects" (p. 70). Additionally Josselson (1995) provides guidance by stating that,"Even study of the most closely observed lives, is not an archaeological excavation but an excursion into reframing a story in search of life plots that better serve the individual in the present" (p. 33).

The form of data analysis, content analysis, was utilized in this study. The stories were read several times in order to address similarities, or themes amongst the stories, as well as highlight differences. It was the meaning of events, in the individuals' stories that was initially highlighted, to see what was cited by the participants as precursors to the development of anorexia nervosa as well as important aspects of the course of the illness. "If one defines narrative as a story with a beginning, middle, and end that reveals someone's experiences, narrative takes many forms, are told in many settings, before audiences, and with various degrees of connection to actual events or persons" (Manning and Cullum-Swan, 1994, p. 465).

The complete stories provided both the context and meaning. "Plot of story, like plot of lives, involves progress toward meaning" (Josselson, 1995, p. 39). It was the context of the complete stories that allowed for the analysis of significant events. Simply presenting the themes, without a more complete

story presentation would reduce participant experience to a trivial level. "By studying the sequence of stories in an interview, and the thematic... connections between them, and investigator can see how individuals tie together significant events and important relationships in their lives" (Kohler Riessman, 1993, p.40). Connelly and Clandinin (1988) concur stating, "storytelling is the process of reconstructing events in the past and is designed to be useful in understanding ourselves in the present (p. 34).

The use of narrative design provided the framework to analyze the data, step by step. Firstly, data were collected through the one-to-one interviews. Then they were transcribed from audio tape onto paper. Both the transcriptions as well as the tapes were reviewed several times while the content analysis was being completed. Initially, the factors participants identified as the precursors to the beginning of the development of anorexia nervosa were identified. Following, data were further analyzed to identify similar themes, amongst all the participants' stories; that is amongst at least two or even three stories. Once the above analysis was complete, the data were analyzed again to identify unique elements within the individual stories. As well, the literature was reviewed during the analysis to note similar themes that had been documented in previous research. Relationships between the existing findings and those data from this study were identified. In addition, themes that emerged, from this study and that were not highlighted in the literature were included. The data were reviewed a final time to ensure that themes, both similar, and/or unique had been documented. The findings were finally categorized under two headings that supported previous research, and

also two headings that were unique to this study.

Credibility

When performing the data analysis, it was important to apply the issue of credibility. Miles and Huberman (1994), describe credibility as whether or not the data makes sense, and is authentic. Brink and Wood (1994) state, "Validity in content analysis refers to the extent to which the categories represent the theme or concept on which they are based" (p. 217). In chapter six, findings and discussion from the study are presented. Initially emergent themes from the data were compared with those discussed in the literature review. Secondly themes similar and unique from an analysis of the data, that had not been reported in the literature were analyzed. The similar findings are presented under two themes, while the findings unique to this study are located under two different themes. The credibility of the research process occurs via the audit trail of the research, and field notes kept after each interview.

Trustworthiness

The participants were contacted and an arrangement was made for an interview. They were told of the researcher's status as a graduate student, and the purpose of conducting the study. The participants were made aware that the researcher was diagnosed with Anorexia Nervosa over twelve years ago. Prior to the interview beginning, the study was completely explained verbally.

The participants were given a description of the study, and encouraged to ask any questions regarding the study, or about the researcher prior to signing the consent form. Due to the age of one adolescent, a parent was also present during the verbal description of the study and signed a consent from. Questions from the parent and participant were answered prior to the interview. Both the parent and adolescent signed the consent form prior to the interview. The other two participants lived independently, thus their consent was sufficient. The consent form was signed prior to beginning the interview. Throughout the study, there was no physical harm nor threat to the participants who participated in the study. There was no disclosure of real names or places and the participants were assured that their identities would be concealed. The participants were told that the information they discussed with the researcher, was going to be taped and then transcribed. The only persons that would have access to the tapes would be the researcher, the research members, and the person who transcribed the tapes. The participants were requested to tell their stories as they remembered them, and were told to tell the parts of the story that they were comfortable with telling. They were told that they could discontinue the interview at anytime, there would be no questions nor ramifications. The participants were asked if they wanted a name of a psychologist, in the event that they may have desired to seek professional help.

Rigor

"Technical rigor in analysis is a major factor in the credibility of qualitative findings" (Patton, 1990, p.472). Patton (1990) stated further, "the principle is to report any personal and professional information that may have affected data collection, analysis, and interpretation" (p.472). Chapter four, the researcher's story, which includes personal assumptions, was included to address the issue of rigor. As well, the participants were informed, prior to the interview, about the researcher, the study, and encouraged to ask questions to clarify concerns. The data were reviewed and analyzed several times prior to deciding upon the final findings. The data included the tapes and transcriptions as well as the field notes.

The benefit of this research, to society, is to increase the understanding of anorexia nervosa within the adolescent female populous. The illness, however, within that populous, transcends age, race, and gender. It is hoped that this research will be a catalyst for further research in other populations, such as males and older women. Perhaps, the focus of further research will shift away from treatment and expand to include research on preventionl.

CHAPTER FOUR

MY STORY

This chapter, has been delayed several times. I have attempted over the last years to move forward in my life from the time period I struggled with Anorexia. Recounting the details of that time period, I knew would not be an enjoyable task. However I concede it is necessary to frame my thesis. My story will allow the reader an opportunity to understand my personal biases and assumptions regarding anorexia, adolescent females, and self-esteem. This chapter will not be used in the data analysis as the stories from the three subjects illustrate a current struggle with the illness. For example, one subject is amidst her struggle while the other two are newly into recovery. Although there will be similar themes emerging from all the stories, my story is "old news". My story will be used in the discussion of the results to address similarities amongst the stories.

To provide a more complete version of my story, when I was battling with the illness, I asked my parents to participate in this research. I believe, that while one person suffers from Anorexia Nervosa, there are several other individuals who are affected.

I will begin with my story. This is my story as I remember it. It is a difficult story to initiate as it has no identifiable beginning. I am also not convinced the story has ended.

My family consists of my father, a land surveyor at the time, who retired during my illness due to circumstances not related; my mother, who returned to the workforce two years prior to my illness as a clerk in a drugstore; my

brother, who was a University student at the time; and myself, a grade twelve student. We lived in a small city in Saskatchewan. My peer group was diverse and varied. One peer group was the peers I had grown up with and who were in high school together. My other peer group consisted of the people with whom I worked. I had started working as a lifeguard two years prior to the onset of the illness at a local pool in town. The job provided me with the savings I had planned to use to further my education.

I cannot recall a critical incident or point of crisis, when the anorexia took hold of my life. I was in Grade 12. I was involved in planning the graduation. Ironically, I was made head of the Reception Committee. I was devoted to self-starvation, yet was in charge of organizing food for over 200 people for graduation! I was also involved in the sports of waterpolo, swimming, weight lifting and aerobics. The later two were encouraged by the friend I was dating at the time. It was the first time I can remember that I actually felt good about myself, both physically and emotionally. The weight lifting increased my confidence in myself. My friend would push my limits, and taught me to believe in myself and my abilities. This would prove to be a valuable skill later on.

Growing up, I had always felt that I never quite "fit in" with the popular crowd. Yet I always had friends. The most popular group seemed to have a circle of people that they associated with but I was always on the parameter. Within my family, I was never socialized to be a female nor did I have the typical "girl" activities imposed upon me. If my father and brother were going fishing, playing catch, even off to shoot gophers, I was always included. I

know my self-esteem was affected, inadvertently, by the teasing from my family, friends and peers. Although it was not mean spirited, it hurt. For example, my family would poke fun at the way I would pronounce a word. Today, my family often uses the mispronunciation in humorous fashion, and it no longer hurts. I loved my family dearly.

My relationship with my mother when I was younger, was often confusing. I loved her dearly and tried desperately to please her, yet I never felt as though I did. We would often argue. I think our personalities are very similar. Two strong willed females laid the foundation for some very heated battle of those wills!

My relationship with my brother has always been one of friendship. I have relied on him often in my life and view him as a life-long friend. He was often the peace keeper when my mother and I were arguing. At the beginning of my struggle, he acted as my confident.

My relationship with my father was always special. My father worked out of town, and I always remember looking forward to seeing his car in the driveway when I returned home from playing with my friends.

My Grandmother, my Dad's mom, has always had a special place in my heart. She often told stories of her earlier years. She raised three wonderful children on little money but lots of love. I always admired her constant faith, strength and determination to persevere, through good times and bad.

I remember always being slightly different than the popular crowd. For example, I was always one step off the fashion beat. The designer clothes that were the style were often substituted for a more affordable likeness. I

remember when canvas *NIKE* running shoes were the style, I had leather *North Stars*. Not having the designer clothes separated the popular kids from those that just did not quite make the grade.

By Grade twelve however, I had established a peer group outside of work that was all accepting. I had friends that belonged to the popular group in school. I was actually quite content with my life. Since I had started working in Grade 10, I had started buying my own clothes, which helped me feel like I "blended in" with the other kids. Ironically, at the point where I actually felt good about who and what I was, was the point that my life would change forever. Life with anorexia changed me and my family members.

At the beginning, when I started dieting I only intended to lose 5-10 pounds, to see how I would look. I was weight training and wanted to see if the muscles would appear more defined. Having never had a weight problem, and never having to watch what I ate, this was a new experience and a new sense of gratification. It did result in a feeling of having control over one aspect of my life.

My parents had established a rigid set of rules regarding my whereabouts and curfew times. The rules appeared restrictive in comparison to my friends, who had very liberal rules to follow. The weight loss began in winter (December-January). The exact dates elude me.

I remember friends of the family who also had a daughter who struggled with bulimia. They confronted my parents regarding what they suspected was my problem. After realizing there might be a problem, our family did seek out a doctor in the local Mental Health department. We went as a family to try and

solve my problem. I remember the doctor making reference to the fact that I had only 3 of the 4 criteria for the diagnosis of Anorexia Nervosa. The criteria I was missing was the 20% weight loss compared to the height weight charts. Since I did not meet the criteria for anorexia nervosa, the doctor gave me a prescription for antidepressants. Actually, he also gave me a goal, to direct my weight loss. I began to lose more weight, in order to achieve said criteria. In my mind, the result was not to achieve the diagnosis of anorexia but it was more of a game. Could I reach a goal set which I had set? The doctor, in my mind had declared a number, and I was about to achieve that number. Prior to the mention of that figure, I had not monitored my weight according to a scale but according to how my clothes fit and how I felt. From that day forward, my weight would be governed by a weight scale.

After my parents decided that the doctor at Mental Health Services was of no help, we tried other doctors in town. The last one who saw me, referred us to a psychiatrist, who was a "Specialist" in the field of Eating Disorders. This doctor would dominate my life for the next year.

In June of 1985, I was called out of Physics 30 class by the school guidance councilor. My father and I had gone to speak with her when the psychiatrist informed us I would be admitted to the hospital, in Saskatoon, when the next bed was made available. On June 10th, it was like a scene out of the movies. The day was overcast and raining. The atmosphere was dreary. It was only two weeks until our graduation. I would miss both final exams and graduation.

My father's back inhibited him from driving great distances, therefore, my mother's brother, my mother and I left for Saskatoon before noon that day. This would be my last contact with my family for several weeks. I would not be allowed to talk to anyone except the doctor. This included the nursing staff. I could not use the phone, the television, or the radio. I could only use the bathroom if accompanied by a nurse. I was not allowed to shower nor bath. In essence, I was confined to my bed. I was to lie flat in bed so I would not expend any calories. I would be allowed to sit up (via the bed being rolled up to full fowler position) when my 3 meals and 3 snacks were brought. Each meal tray sat before me until all food was consumed. There would be a time limit installed if I was to take too long to eat a meal. It was perceived that I would be wanting to sit up longer to burn more calories. I was told if I vomited what I ate that they would place it in a jar and place it at the end of the bed for me to look at. At the end of the bed was a chart that would plot my weight gain for my stay. I viewed it as a map to freedom.

Once the preset goal weight was achieved, I was allowed to walk about the unit. Having been on bed rest for several weeks and the fact that my body weight had increased since my legs last supported me for any length of time, it was a different experience. My mind remembered how to work but my body had not experienced it in a while. My legs felt weak beneath me, I was kept in the hospital about two weeks from when I was able to move about in the unit. If I did not maintain the weight while being mobile, I would be placed on bed rest again. Being on a psychiatric unit I found it was a terrifying experience for me. I had come from a small city, population 15000 , and I was not sure of

what to expect. The milieu was very different from what I was used to at home. While I was on bed rest, I was in the far corner of the unit, so I had very little interplay with the unit.

I was discharged from the hospital mid August. I had enough time to prepare to attend University that September. My brother had selected my classes for me, earlier in July. The apartment was rented, so I moved in.

By the end of September, my weight loss was dramatic. The weight I had gained only two months before appeared to slide off me like water. I was re-admitted to the hospital the first week of October. I was under the care of the same doctor. I would follow the same regime as my prior admission. I was released mid December, after achieving the preset weight again. Within a few weeks, I was admitted to the hospital in the small city where we lived, for just over a week. I was discharged only a few days before Christmas. By the first week in January, I was re- admitted to the hospital in Saskatoon. Once again, under the same doctor and to follow the same regime. This would be my third attempt to conquer the illness.

This admission was different than the previous. I felt that there was a conspiracy between the doctor and my parents. We had only gone to see the doctor for an appointment not to be admitted to the hospital. The doctor had told me I had two choices: one was, to be admitted to the hospital; the second, was to no longer be one of his patients. The choice in my mind was obvious. I would no longer be one of his patients. He called my parents into the room. They did not agree with my choice. I was dropped off at the admitting department of the hospital. I was lead to believe we were going up to

Saskatoon for an appointment only. Being admitted, once again to the hospital was not on the agenda. Due to my belief that my parents and the doctor had contrived this plan, I felt my relationship with my parents was severed. They had betrayed me, and for that, I could not forgive them. My contact with them for the next year was very limited.

The last hospital stay went until the first of April. This time when I was discharged, I left with only the sports bag of clothes my mother had sent on the bus, in January, after I was admitted. I remember feeling somewhat lost. I knew I would never return to the "prison" I was released from that day. Prison is how I viewed the hospital. I knew I was not returning to my parents. I walked out of the hospital, knowing I was indeed on my own. I was in a strange city that I did not know well. And I had no idea where to go. I finally decided on the YWCA, until I could get my feet on the ground.

I had saved some money while I was working in high school, which I used to help me get my feet on the ground. By the first of June, I had obtained an apartment, two part-time jobs as a lifeguard, and I had registered for a class in summer session at the University. I had also managed to loose most of the weight I had gained while in the hospital. When I left the hospital, I also left behind the services of the doctor. I was on my own, and not doing all that well. Eventually, I lost the jobs because of the weight loss. For transportation and for weight loss, I would ride my bike everywhere.

I went to register for a Fitness Appraisal course at the university in Saskatoon. The course content was to measure the body fat of participants and design a fitness regime for them. The professor in charge of the course,

suggested I not take the course. It was his opinion, that my current state of health would be in jeopardy. If I passed the course, I would be a Fitness Appraiser who would be measuring body fat of those that consulted me. I registered for the course and passed. It gave me motivation. I was going to prove to everyone I could not only pass that course but I would graduate with my degree of Physical Education in 1989. I choose that year because if I would have continued in university in 1985, I would have graduated in 1989.

Even upon my graduation, though I had managed to maintain my weight gain, I had not conquered the psychological issues. I was unable to cook for myself, properly and my weight was the most it had ever been.

After graduation from university in Saskatoon, I went to University of Alberta, in Edmonton for three weeks trying to gain admission into the Occupational Therapy program. The professor gave us daily projects of addressing our personal issues. I tried writing letters to my parents addressing how I had felt growing up. The relationship hit a very tenuous level. The relationship with my parents finally resolved six years ago when I had open heart surgery. Facing one's mortality for the fourth time in eight years, tested my inner strength. My mortality was confronted three times with anorexia, and now again for the open heart surgery.

The time period of anorexia was one of the best moments of my life. It provided me with the greatest point of emotional growth. I grew as a person, learning to depend on my own resources. I also developed a greater spiritual side. My Grandmother, provided me with an excellent example, of persevering in difficult times. While I was alone in my room in the hospital, I utilized the

resources my Grandmother modeled for me. I developed an even stronger faith and belief that would help me survive. When I was released from the hospital, I sought out Eastern philosophy. It seemed to address issues of developing as an individual. Improving myself as a person and becoming the best person I can be, lies at the root of the philosophy. My spiritual side has continued to grow since the beginning of my journey. My personal journey began as a result of my encounter with anorexia nervosa. It continues today.

I asked my parents to comment on the time period during which I struggled with anorexia. My father at first had only one sentence. Below is my father feelings.

> I would like to commend Karen for her courage, strength, determination and faith in overcoming this dreaded condition. As a parent, I felt responsible and often wondered what part I had in her becoming ill. I regret that after having gone through the experience, and learned very little, that I am unable to help others in a similar situation. Except for my personal doctor, the "health professionals" were a big disappointment. From what I have seen since our experience, things have not improved a great deal. This was the most difficult period in my life and it is my sincere hope that one day soon a cause and a treatment will be found, to help sufferers and family alike to overcome this terrible condition.
>
> (Correspondence February 4,1998)

My mother also described her feelings regarding our family's encounter with anorexia.

> Before anorexia invaded our household, we knew nothing about the problem. The initial behaviors of dieting and exercise, were not the warning signs they should have been. There were a lot of tears and guilt, at the beginning. When our daughter was admitted to the hospital, I naively thought, we were on the road to recovery. We could not visit or contact her until she reached a certain weight and this reinforced the guilt feelings. It was difficult to watch her struggle with anorexia and be unable to help. We were afraid of saying or doing the wrong thing and this increased the tension between us. After three hospital stays she took control and began to get some "normalcy" back into her life. Thanks to her strength and determination, our story has a happy ending.
>
> (Correspondence March 12,1998)

My research was started, to gain insight as to why I chose anorexia and perhaps to understand what precipitated in my life, at that time, that made anorexia a reality. I do not believe my initial trial with dieting contributed to the development. Nor do I believe anyone contributed to the development of anorexia. I do believe the struggle with anorexia, challenged me. I did become a stronger person as a result.

CHAPTER FIVE

ADOLESCENT STORIES

This chapter will share, in a summarized format, the stories of the participants of this study. The names of the individuals have been changed, to keep their identities concealed. The stories will be presented in the order that the participants were interviewed.

Melissa's Story

The first interview I conducted took place on January 16,1998, at her home. The participant was currently within her struggle with anorexia, which I did not know prior to the interview. Melissa lived at home with her family. When I arrived at her home, she was just returning from school, with her Mom.

I remember the first thing that I noticed was her clothing. This beautiful young girl was almost hidden behind the clothes she was wearing, that were purposely over sized for her frame. Her mother suggested we use the basement for its privacy, to conduct the interview. Her mother was asked to join us downstairs, so I could explain the purpose of the study, answer any questions prior to the signing of the consent forms. The mother did have a few questions regarding the intent of the study, as well as my plans after it was complete. The mother then proceeded to share with me that her older daughter had anorexia, years before, in connection with another medical problem. As well, the mother had a sister that had Obsessive-Compulsive Disorder, who had written a book about her experience with the disorder. The story that her

sister wrote, did not represent, in the mother's eyes, the reality that took place. The mother also stated that the story that her daughter was about to share with me, was no different. The mother stated, in front of Melissa, that the story her daughter was about to share with me was her daughter's version, and that it might not be entirely accurate. I responded, that it was her daughter's version of the story that I wanted, as the details that her daughter remembered were valuable to my research. With the departure of the mother, to give us privacy, I asked Melissa to start at what she felt was the beginning of her story. I asked her to share with me the parts of her story she felt comfortable sharing. The story that follows is written in third person, in a condensed form.

Melissa's struggle with anorexia began in Grade 8. The decision to achieve a more slender appearance was done inadvertently. Over the summer holidays, she had a growth spurt. The result of the growth spurt, stretched her previously "chubby" body, and left her more slender than before. The weight loss was noticed by her peers, and made her aware of the attention that resulted from her transformed exterior. "I was kind of chubby, and then over the summer I lost a lot of weight, and it felt so good to hear people say, 'You look good'". Before the weight loss, "It was like I was there, but I didn't have to entertain them or please them." The amount of food that was consumed everyday became less and less in order to maintain the slender appearance, and the peer group she had now acquired. "I was self-conscious". Later on in the interview, Melissa stated, "I wear big clothes so people can't see if I'm thin or fat." Melissa described how, "the anorexia kept telling me, 'You have friends now that you've lost all this weight. Maybe if you lose more, you'll get more

friends now'."

A few months into careful selections of food, exercise was added. Within a month after the exercise was added, the weight loss was noticeable. The amount of exercise done per day was a lot but not excessive. A few more months had past when she noticed that her skin was becoming splotchy. Melissa stated that "I was really, really, really sick...I still thought I was fat. I wanted to lose more weight". It was at this point that her mother recognized that her daughter was not eating. Her mother decided to weight her daughter every morning. Her mother told Melissa that if she continued to lose more weight, that she would be taken to the hospital. Melissa found a way to trick her mother, that the weight loss was not as great, by putting ankle weights on when she was weighted. Her mother discovered her trick, and at that point Melissa was twenty pounds less than both realized. At that point, her mother took her downstairs, and made Melissa eat a pizza pop. Melissa described that as "the hardest time of my life. I hadn't eaten in eighteen days. It was so hard". A short time after the family went on a vacation and Melissa did not exercise.

Upon return from the holiday, Melissa began exercising again, but the amount was less than before the vacation. Melissa also began reading books on anorexia. She discovered that she was counting fat calories, but those anorexics she was reading about were counting other calories. The knowledge of the calories in food prompted her to begin exercising more. Melissa's mother made her daughter consume a protein shake a day. Melissa knew the fat calories in the shake, and exercised more to rid her body of those calories. The amount of exercise that Melissa was performing was becoming all-

encompassing. "It was just totally taking over my life. I couldn't do homework or talk on the phone. I would just exercise and hide food". Melissa also stated that she was of the Catholic faith and it bothered her that she began lying and cheating about what she had eaten. She also felt her dietary habits were under scrutiny by her mother.

In the spring Melissa added running to her daily exercise routine. As well, she added biking to her plans for the week of activities. Within a month of completing the school year, Melissa's mother pulled her out of school completely to make sure she ate lunch, at least. Melissa, at that time, decided that she needed help. The decision, to seek help, was not clear in her mind. "I just wanted to get rid of it (anorexia), and then it would just take over." Melissa described a double personality, one that wanted to pursue help, the other that did not want to let go of the anorexia. Her mother did take her to see a doctor who stated that there would likely be a hospital bed in two weeks.

In the meantime, Melissa's mother made her stay on one level, in the split level home, to avoid using excess energy. Melissa was also put on an all liquid diet. Her mother gave her two protein shakes a day. Melissa found a way to address her need for exercise. When her mother went to the bathroom, she would exercise as fast and as much as she could, for that time period.

Melissa celebrated her birthday two days before going into the hospital. "Then I got to the hospital, and that was awful; that was bad". The first meal that she was to have in the hospital dredged up a lot of fear in Melissa. "I just started screaming". Melissa was not forced to eat the meal. Instead, she returned to her room to exercise. When her parents came to visit, "I just begged

them to take me home; it was awful". One night she recalled, it was Family Night in the hospital, and Melissa had enough of the hospital. "I was just begging, and I was like, 'I'll kill myself. I swear, I'll kill myself if you don't take me home". At that point, it was only a threat from Melissa.

Melissa soon became aware of other kids in the hospital that were cutting their wrists. She also confessed that there were drugs available, within the unit. Her description of this portion of her hospital stay was, " the hospital was a joke". The self-mutilation was her education in the hospital. "It was like an addiction, where you have to do more". There were other anorexics in the hospital. In Melissa's mind there was a competition between them, to see who could loss the most weight.

Melissa's hospital stay lasted two months. At one point she was transferred from the youth unit to the adult ward. In the adult ward, she was given six to seven meals a day. "I was in a glass room, and had to lie on the bed." In order to be released, Melissa had to achieve a set weight. This took her only three weeks. "I love food, but I also was scared of it". After her discharge, Melissa was still eating, but it was only a matter of time before exercise crept back into her daily agenda.

After Melissa completed sharing her story, I asked a few questions. She had described being self-conscious, after she began dieting. I wondered how she felt before she became aware of her weight. Melissa told me that prior to her weight loss, she did not care what people thought. After the weight loss occurred, "there were people who liked me because I was skinny". After people noticed her weight loss, Melissa felt obliged to consider what other people

thought, and try to please those other people. Melissa described herself as a having a healthy appetite before the preoccupation with food began. But as the weight loss progressed, "I started to get more depressed. I really didn't feel anything anymore. I still don't". Melissa was acting differently on the outside than she was feeling on the inside. "I couldn't go around being depressed and everything, so I put on an act. I acted happy."

At the completion of the interview, I asked Melissa if there was anything else that she would like to share about her story. She eagerly told me about a little boy, 3 years old, that she described as her best friend, "that's the only thing that has kept me going." Melissa added, "He is the only person I can be myself around, and he likes me."

Researcher's Comments:

Melissa's story touched me in more ways then I can describe. As she told her story to me, I was touched by the amount of pain she was feeling inside, yet I think she remained unaware. Before me sat an incredibly beautiful person, beauty that was emitted from the inside out, and the undertone of her story was that she did recognize her value. I asked her how she was feeling right now. "I'm getting really depressed right now. There's weeks when I'm really depressed and the suicide thoughts are getting worse." Melissa had an incredible analogy to describe how she felt when she was lying to cover up to her mother how little she was eating. "I felt trapped. I felt like I was drowning, you know? Like someone was taking me over. Like it was a sunny day covered by fog." The fog was the anorexia. In my mind I thought what a perfect

analogy, if only she believed that the sun can shine again. I saw the sun as her self hidden by the anorexia.

Susan's Story

The second interview I conducted took place on the University campus, for reasons of convenience, on January 21,1998. The academic setting in hind sight, was appropriate for Susan's story because her story began with an intellectual presentation, that displayed a lot of insight into her story. She had told me on the phone that she has told her story before, to High School students, to try and help them understand what life with anorexia is really like.

Susan's story began when she was eleven years old. She was going into Grade six in the fall. During the summer, she was at the cottage when her mother remarked at the few pounds that Susan had gained. It was Susan's grandmother that commented that the boys wouldn't like her if she was too fat, so she had better start watching her weight. In hind sight, Susan realized that she was not overweight, in grade six. At the time the messages of her mother and her grandmother had made an impact. Susan also remembered her family moving, prior to the start of Grade 4. Prior to the move, she felt that she was part of the popular crowd. This was not the case after she moved. "I never wanted to be with my peers; they didn't interest me. So I really started to withdraw a lot from that , and I was teased a lot in Grades 4-6."

To begin with, Susan began cutting out second helpings, desserts, and snacks. She also made a list of foods that were good and bad foods. Her established eating agenda left Susan feeling high and in control; "I felt high. I

felt in control. I felt successful and most of all I felt numb." The self-imposed food restrictions, lasted through Grade 6 and Grade 7. The amount of calories Susan consumed at this point was extremely minimal. Susan recalls knowing that everyone else required food to exist. "I believed that I was different; that (food) wasn't what my body needed."

It was at this point that she started lying to her mom about what she ate. "I hated being dishonest. I hated the lying." Her mom tried to attempt to control Susan by "blackmailing" her into eating. For example if you eat _____, then you can do _____. For Susan, the thing that she wanted to do was attend ballet class. It was this point in her struggle when Susan described the amount of exercise as increasing. Susan admitted excusing the amount of exercise that she did, as part of her training in ballet. She was in the professional stream of ballet. Admittedly, "What I was really doing was trying to lose weight, of course." For Susan, the obsession began. "I was obsessing constantly about food, weight, calories, what I couldn't eat, what I could eat, what everyone else around me was eating." While Susan's mind obsessed about food and weight, inside she felt irritable, restless, discontent. Susan stated that her concentration was nil. Yet, she managed to hide the fact that there was anything wrong, by obtaining top marks in school and being on the honor roll. Susan admitted that she used her achievements to try to fill her up inside and feel worthwhile. "And a big part of that for me was also the thought that everything is okay, putting a smile on my face, and 'Oh, I'm fine,' when really, inside, I felt like I'm dying."

Susan said she had no memory of grade 8. The exercise was progressively increasing. It was in grade 9 that Susan began binging and purging as well. She had learned about it in health class. Susan recalled thinking that was the answer. She could consume whatever she wanted because she could rid her body of the calories. At the end of grade 9, Susan had an suicide attempt. Although, she never tried suicide again, the thoughts were always there in the background, along with depression. During high school she said she experienced a continuation of the exercise and food restrictions. The frequency of binging and purging, as well as the exercise, increased by the end of high school. Susan described a feeling throughout grades 7-12 as, "a black hole that sat right here, at the sternum, and it just kept growing and growing and growing. It was a pit of despair and loneliness."

It was at this point, that Susan sought help. She stated that she wanted to terminate the bulimia, but still wanted to be anorexic. Susan started reading every book that she could find on Eating Disorders and she also consulted a variety of persons in the medical profession. She said, "Basically, I tried everything out there currently on eating disorders, and nothing worked, because it never changed what was going on in my mind." At one point, Susan said she was told by one doctor that she would never recover. The best that she could hope for was to function and move on with her life! She felt that she had been labeled as hopeless.

Susan attended a Professional Ballet School, after high school. The school warned her that they would not keep her if her eating disorder was active. Susan kept from binging and purging, as a result, but only for about

one month. "As much as I tried, as much will power as I exerted, it (her will power) didn't work, because what would happen was, I know it (binging and purging) wasn't okay, but at the last moment the thought would drift through my mind that it (to binge and purge) was okay to do this time and that I needed to do it." As a result of needing to fit her binging and purging into her day, she began skipping school. Susan also confessed to using caffeine pills and over the counter diet pills, to keep going. She obtained a number of successive injuries and she was warned about dancing with them. "I wasn't willing to stop." Susan was driven by her fear of weight gain, so she started taking codeine to kill the pain, and Gravol for the nausea.

During her second year at the ballet school, she said that she began compulsive eating. This period only lasted about three months as the weight gain was unacceptable to her. The old habit of starving and then binging and purging, returned. Susan became apathetic about school, her grades, her performance. She did confide in a preceptor at the school, who started her eating soda crackers, and drinking apple juice. "The despair and the pain were just incredible. All I saw was blackness and again just constantly thinking about suicide." By early spring of her second year at the ballet school, Susan began to crash "big time". She got sick with laryngitis and stopped eating. "And I had come to the place where I couldn't care, and I think that was the hardest place." Susan described further, "I went through about a month that I just didn't go to school." Susan said she felt " in that deep dark place of hell, that's really the way I described it, was living hell." It was at this point, Susan decided to leave the ballet school and return home. "I knew that I was going to

die if I didn't."

Her struggle with anorexia had cost her: her school, her friends, and even, her identity. Susan states, "I had lost my own identity; I didn't know who I was. I was the disease; I was anorexia; I was bulimia." Susan recalled reading books. On one level she wanted to stop her struggle, but at the same time she was picking up "tricks of the trade". Susan's struggle had her also trying to intentionally dehydrate herself.

Susan's story does have a happy ending, as she did manage to locate a doctor who was able to help her. She has been in recovery for two years. The recovery process for Susan was not without its share of ups and downs. It certainly did not happen immediately for her. Susan is currently applying the Twelve Step model in her recovery. Using the model has brought a sense of being and sense of worth back into her life. She stated that it has helped to clear a lot of wreckage of her past. Susan works at her recovery everyday.

At the end of her story, I did have a few questions for Susan. I wanted to know if the pressures of ballet contributed to her struggle. She stated, "I'm sure it contributed to my choice of addiction, in that it definitely encouraged the thin, being very thin; and the compulsive exercise and all that was very much encouraged with this. I'm sure it did not help any. I definitely do not hold it responsible." Susan added near the end of the interview, "And I believe that I would have been an anorexic and bulimic even if I hadn't been in dancing." When Susan and I discussed the length of her struggle with her illness, Susan described, "I'm definitely aware that my self-esteem became more and more nonexistent, my sense of self-worth. And especially as time

past, feeling less and less deserving of recovery, of getting well, and of anyone else's attention or time." Susan said she valued her perfectionism, and believed that she was nothing without achieving.

When discussing her recovery, Susan stated that she has been able to develop an internal sense feeling that she is okay, and that it is okay to be real.

Researcher's Comments:

After I left my interview with Susan, I remember feeling an array of emotions. This individual had figuratively climbed *Everest* several times in her life, and had survived to share her memories with me. The pain and despair, she experienced in her life began at such a young age (Grade 6). Her struggle with her eating disorders had caused her to lose sight of who she was inside, and only recently has she begun to rediscover who she is. Beyond all the despair, and pain that she experienced, she currently possessed an incredible sense of peace. I could not help but think of the amount of internal strength that she must possess in order to survive and grow from her life filled with anguish. I remember thinking, that I should remember Susan's story, when I believe that my world is closing in around me, to give me some perspective, but also, motivation to carry on.

Rachel's Story

The last interview that I conducted, was with Rachel at her home, February 3, 1998. She lived in a school residence, in a single room, which provided a quiet, private atmosphere. Our meeting time was at the end of the dinner hour, so Rachel carried with her to her room the last portion of her supper.

Rachel's story began when she was fifteen, in her first year of high school. Prior to her weight loss, she said she was never concerned about weight. She described herself as healthy and active. Rachel also admitted to being a high achiever. She was at a volleyball camp in summer, when she noticed a picture of herself in a bathing suit. She thought that she should loose some weight.

Going into high school, Rachel presented a confident exterior. Inside, she did not feel that way. She noted that years of teasing and being picked on by her peer group, growing up, had eroded her self confidence, "So, I had a low self-esteem". The teasing made her feel, "I just never felt like I quite fit in." Rachel adds, "I guess I always felt like I was sort of on the fringes."

Rachel was determined to make the volleyball team, in her first year in high school. When she did not make the team, she felt devastated. However, Rachel said she tried to pretend that she was unaffected by the coach's decision. In her Grade 9 year, Rachel recounted that she decided not to allow anyone to see that they had hurt her. In hind sight, Rachel believed that was the catalyst to "stuffing" her feelings. She also stated that concealing feelings was part of her upbringing. At the time that she did not make the volleyball

team, an older boy started liking her. This relationship introduced her to partying and drinking alcohol. When she did drink alcohol she felt like she fit in with the friends. It was also the attention from the older boy that started her thinking about her weight. She began by trying not to eat during home economics class, and she also made a list of what she had consumed that day. If Rachel did eat something, that she had evaluated as a food she should not eat, she would devalue herself by calling herself a weakling with no will. She has an old diary, which has a list of good foods and bad foods.

Rachel decided that since she was not successful in her attempt to make the volleyball team, that she would try out for the basketball team. She was going to become an athlete and get healthy. Rachel replaced her alcohol consumption with exercise such as running. She noted, "And it was at the same time that *Oprah*, started 'Get fit with *Oprah*' on television." Rachel recalled pondering, " why do those people have trouble losing weight, because if I set my mind to it, I can do anything." The decision to put her mind to it, resulted in Rachel going for her first run after Christmas and the decision to cut back on second helpings and snacks.

The weight loss was rather quick. Rachel recounts, "And I remember trying on my first pair of jeans, and it was just like I had conquered the world because they were smaller than I'd ever worn, ever, and it was like I could do anything." With the increase in weight loss came an increase in the attention she received. "People were all telling me how good I was looking. I started getting more dates and more compliments." With the increase in attention and positive feedback, Rachel started to feel better, but those feelings changed.

She stated, "And then somewhere along there I started not feeling very good. Something changed. I don't know how it did or what changed, but it wasn't good."

The change in feelings brought on a different activity. Rachel reported that she began binging and purging to help control her weight. "And I remember watching that in health class and thinking that it would never, ever happen to me." The last time Rachel tried to make herself vomit, it really hurt. The pain scared her. Her desire to become healthy was contradicted by this purging behavior. She decided at that time, every time that she felt like vomiting, she would go for a run instead. "Every time I ate something, I'd immediately go out for a run." Rachel was also involved with several different activities after school, that allowed her to miss meal times. When Rachel was home at meal time, she controlled the kitchen, so she would know what was going into her body.

The running brought about a sense of accomplishment. "Just like I was glowing, like the sun was shining up through me." Rachel was up at six o'clock every morning to go for her first run of the day. To satisfy her desire for more exercise, she began to skip classes to go running. When she ran home after school, her knapsack, was filled with her textbooks. Despite all the running that Rachel was doing to feel good, inside she felt depressed, unhappy, and could not concentrate. She described, "I was totally numb." Rachel felt that the only time she was happy, was when she was running. The time commitments to her running, isolated herself from her peers. She said, "I didn't have time for friends, and I didn't deserve them." She excused the

amount of time that she was running by telling people that she was training for a marathon. Rachel bought books on weight loss, to assist her in her strive to become healthy.

The first time Rachel went to the hospital, was after a run because she had diarrhea, cramps, swollen tongue, and difficulty breathing. She had previously visited a doctor because she had stopped menstruating, however, the doctor informed her mother and Rachel that only Olympic athletes lose their period from extensive exercising. Upon a repeated visit to the doctor, Rachel was weighted, and was found to be significantly underweight. The doctor referred Rachel to a sports nutritionist. The doctor also suggested that Rachel's mother to start feeding her with pablum. Rachel mentioned that her mother also tried to tempt Rachel by cooking some of her favorite foods.

At the end of Grade 10, Rachel passed all her courses, and achieved 100% in math. She said that her high grades convinced everyone, including her teachers, that everything was okay. The following summer she recalled, was filled with endless runs. Her birthday was only a few weeks into the summer holidays, and she imagined that everything would be okay after that day. Her birthday came and went but nothing changed in Rachel's life. The old patterns persisted.

Prior to attending a sport's camp that summer, Rachel weighted herself upwards of seven times a day. For the camp, she found a measuring tape, and began monitoring her measurements. Despite all the exercise, and monitoring, "When I looked in the mirror, I didn't see a skinny person, that's for sure; I just saw the more weight that I needed to lose." While at the camp, her mother

arranged for her to have vegetarian meals, instead of the usual hamburgers and fries. She stated, "And at camp, I was told I was so beautiful; people just raved over how beautiful I was. And they asked me if I modeled before." Throughout camp, Rachel exercised and continued to tell people that she was training for a marathon.

By this point in her struggle, Rachel perceived that her parents were becoming desperate. Her hair was falling out. Rachel did contemplate suicide, but felt that she could not carry it out, as she did not want to disappoint her parents. She stated that her mother was very sick after she was born, and Rachel believed that it was her fault. She promised herself, to do everything for her mother. "When I look back, it was almost like I mothered my mother. I was never a real kid; I was always an adult."

It was Rachel's sister who had mentioned to the family that perhaps she was becoming anorexic. Rachel reacted negatively to the comment, thinking that she was not anorexic. She was an athlete. At this time she said, her parents started using "tough love" to try and reach Rachel. They said comments such as, "You're just a skeleton, and you look disgusting" . Later, Rachel' parents asked her if she would attend family counseling and she agreed. Rachel felt as though she was the glue of the family, holding it together. "I felt like if I didn't keep our family together, it was going to fall apart and Mom and Dad would get a divorce, and it would be my fault, and my sisters wouldn't come home anymore." At a family counseling session, Rachel divulged that she had been bulimic. The doctor gave Rachel and her parents one copy of the book entitled *Feast and Famine* by Dr. Joan Johnson. First Rachel's Dad read

the book, and then she read it. Her denial melted away because she no longer felt alone with the feelings. Rachel's attempts to begin her recovery process met some obstacles at the beginning. She has been in recovery for one year and her devotion to her recovery continues on a daily bases. Rachel noted that her family continues to be supportive of her and her recovery.

When Rachel had completed sharing her story, I did ask a few questions to clarify some points. Rachel described that she still has "rough days" in relations to her feelings, so I asked her how she deals with them now. She described using a technique she found in another book, to stay with her feelings and acknowledge them. Rachel described further, that for her she is the most important thing and everything else comes after her needs are met. She spoke very affectionately about her family. Her one sister is an important segment in her support network, and they talk everyday.

Researcher's Comments:

At the completion of my interview with Rachel, I had a sense of calm and peace. I felt that Rachel was going to be very successful in her recovery, but also in life. Her gentle demeanor, I think reflects who she is. I left the interview with a warm feeling, believing that Rachel would be alright.

CHAPTER SIX

Findings and Discussion

This chapter first reviews the purpose of the study, and what the findings revealed about the purpose. The themes of self-esteem and connections with family are addressed, comparing the findings from the literature to those from this study . The themes of self-mutilation and suicide that emerged from the findings, are also addressed. As well, the participants' attempts at recovery are highlighted. There will be additional comparisons of the findings to the researcher's personal story, to identify any connections that emerge. Finally, implications for further research are discussed.

The Purpose of the Study

The purpose of this study was to collect stories from young adolescent females who are experiencing or have experienced anorexia nervosa to understand why the illness develops, as well as the course of the illness itself. Melissa stated she thought it was a growth spurt which occurred over the summer holidays that began her struggle with anorexia nervosa. The end result of the growth spurt was a more slender appearance when she returned to school in fall. Melissa stated, *"In Grade 6 and 7, I was kind of chubby and then over the summer holidays I lost a lot of weight, and it felt so good to hear people say, 'You look good' And all these guys were asking me out and everything."* The change in her appearance, in Melissa's mind, contributed to an increase in attention she received from her peer group. In part due to the attention received, she set out to maintain the slender image by carefully

watching what she ate. Melissa recalls thinking, *"So I thought maybe if I was skinny I would have more friends."* With fear of gaining weight and the perceived resultant lose of attention, her attention to food selection increased. Initially, she did not consciously begin to lose weight nor take a more slender appearance. She said, *" I wasn't exercising or anything."* This however, was not the case for Susan.

For Susan, it was a comment made by her mother about what she perceived as pre-pubescent weight gain, that instigated her scrutiny of food selections. She recalls, *"I was eleven when I first got sick, and that was the summer between Grade 5 and 6. I had put on a few prepubescent pounds just before I started menstruating...My Mom and grandmother commented that the boys wouldn't like me if I got too fat."* Susan also remembered, *"We had moved before I started Grade 4...I always kind of remember being popular and really in the social crowd and when we moved I really started to isolate a lot more."* Susan's struggle with the illness lasted about nine years and had several transition points. These transitions points occurred when she added a different activities to battle anorexia nervosa. Susan stated that feelings of control, success and even numbness, reinforced her chosen behavior. She said, *"I felt high; I felt in control; I felt successful; and most of all, I felt numb."* The number of calories she consumed began gradually to decrease and her feelings of control and numbness increased. As her self-esteem lowered, she attempted binging and purging. Susan stated, "(It was) *February of Grade 9 that I started binging and purging as well."* Her struggle did not end there.

When injuries threatened the amount of dancing and exercise she could perform, she added prescription and over-the-counter medication. Susan stated, "*I got into caffeine pills...I started getting into codeine to kill the pain, and then the codeine made me nauseous, so the I got into Gravol, and amphetamines.*" In conclusion, a comment about a slight weight gain by her mother, began the particiapnts preoccupation with weight loss.

Rachel, began her struggle by attempting to become healthy, in grade 10. She recalled that because she did not make a school sport team she decided to become healthy and try out for the next team. She recalls, "*I wanted to get healthy...and I was going to start exercising and running.*" The quest began by carefully selecting the food she would eat. She stated, "*I'm not sure when but sometime during that period I started writing down at night what I had eaten all day...I remember making a list of good foods and bad foods.*" Her struggle progressed to include a regular rigorous exercise regime. As weight dropped off and a more slender appearance emerged, so did the attention she received. Rachel remembers, "*And then I was starting to think about my weight; now that the big guys were looking at me... It was in home economics class and I'd make promises to myself that I wasn't going to eat whatever we made.*" The increase in attention from her peers reinforced her preoccupation with slenderness, yet originally her weight loss began as a desire to become healthy.

For each of the female adolescents, the reason why their struggle with anorexia nervosa began, was different. Rachel wanted to become healthy. Susan's struggle began after a comment was made by her mother. Melissa's

struggle began after a growth spurt made her appearnce more slender.

Self-Esteem

The catalyst to becoming anorexic was different for each participant. The first theme that did emerge from the stories of all the participants was a feeling of low self-esteem. Self-esteem is discussed in the literature in association with eating disorders (French, et al. 1995; Button, 1993; Bryant and Kopeski, 1992; Silverstone, 1992; Garner and Garfinkel, 1982). As well, Akridge (1989) cited, "A lack of self-esteem results in a feeling of inadequacy and inferiority" (p.29). Melissa remembered prior to anorexia occurring, "*Before it was as though I was there, but I didn't have to entertain them or please them.*" Similarly, Garner and Garfinkel (1985) believe self-esteem to be an important factor in adolescent girls' vulnerability to an eating disorder. Rachel stated, "*I just never felt like I quite fit in. I felt like I was sort of on the fringes.*" Susan described the following feeling, "*I'm definitely aware that my self-esteem became more and more nonexistent.*"

Connected with self-esteem is self-concept. For example , self-concept is discussed by Osborne (1996) to describe attributes, abilities, and attitudes that identify who an individual is. He also describes self-esteem as a positive or negative feeling about self based on one's capabilities and limits. Two of the participants in this study mentioned how they evaluated themselves based on their personal achievements. Rachel stated, "*I was a very, very high achiever. I wanted to be the best at everything that I did...I had always based myself on my*

achievements." These findings relate to what Striegel-Moore et al. (1986) found; individuals who sought perfectionism in many areas of their life also aspired to be thinner. Susan admitted, *"I was very much a perfectionist... producing top marks and being on the honor roll."* She elaborated further, *"I came over the years, to use a lot of my achievements to try and fill me up and feel worthwhile, as though I was okay."* Self-esteem is defined by Silverstone (1992) as a sense of contentment and self-acceptance that originates from individual appraisal of personal worth. As well, Kagan and Squires (1984) describe how anorexic females failed to meet their expectations and expectations of others. The participants in this study described using a facade to portray someone other than who they really were inside. Rachel described, *"I didn't have time for friends, and I didn't deserve them, and I was a bad person...If people really knew who I was they wouldn't like me."* Melissa described her facade, *"I couldn't go around being depressed and everything, so I put on an act...and I acted happy...and nobody thought I was depressed or anything."* Susan remembered, *" Inside I would feel like I'm dying...and I very much kept up with the facade and really plunged myself into my work."* Yet despite the portrayal on the outside, inside the participants described a completely different feeling. Melissa stated, *"I started to get more depressed. I really do not feel anything anymore. I still don't. I do not know how I think anymore, because my whole focus is food."* Melissa was still struggling with anorexia nervosa at the time of the interview. She described, *"Right now I have this big hole and I do not know how I feel...I'm getting really depressed right*

now...I feel right now I have this big hole and I don't know how to fill it." Melissa described an analogy of a sunny day that was covered by fog. The fog represented, to her, the anorexia nervosa. Rachel remembered a transition in her feelings. *"And then somewhere along there I started not feeling very good. Something changed. I don't know how it did it or what changed, but it wasn't a choice anymore* (the amount of exercise she performed regularly). She stated further, *"And all I felt was loneliness and despair...I was so depressed and I just wanted to die."* When Susan was dieting she described, *"I felt high; I felt in control; I felt successful; and most of all I felt numb. It was a way to numb out feelings."* Susan also described feelings of restlessness, irritability and discontent. As her struggle continued, she used an analogy, *"A black hole that sat at the sternum, and it just kept growing and growing. It was a pit of despair and loneliness...And the depression was ever constant."* Near the end of her struggle, Susan described this feeling, *"really in that deep, dark place of hell. It was a living hell."*

There are common themes that emerged from the stories that provide background to the participants' feelings. Susan and Rachel recalled being teased by their peers. Researchers, Thompson et al. (1995) described a history of teasing amongst subjects with disturbances in body image and eating. Similarly, Maslow (1970) concurred that healthy self-esteem is based on respect from others. Susan recalls, *"I was teased a lot in Grades 4,5,6 about being teacher's pet and a goody-goody."* She stated later, *"The low self-esteem with the teasing, drawing from my peers and such, definitely exacerbated*

the disease." Rachel remembered, *"I was teased a lot growing up; I was always picked on...about being a weakling... and just never felt like I quite fit in."*

Another theme that emerged was that two of the participants recalled not being noticed until their weight loss became evident. Garner and Bernis (1985) stated that diminished self-esteem was a result of self starvation but that low self esteem precluded the weight loss. Melissa recounts. *"It felt so good to hear people say, 'You look good' and all these guys were asking me out and everything."* Both Melissa and Rachel were asked out on dates and had a sense of being popular. Rachel remembers, *"And so at the same time a boy started liking me, and I'd had boyfriends before, but his was an older guy...Now that the big guys were looking at me, I started to think about my weight."* Later in the interview, she stated, *"People were all telling me how good I was looking. I started getting more dates and more compliments."* At a sport's camp in the summer Rachel received more accolades, *"And at camp I was told I was so beautiful; people just raved over how beautiful I was. And they asked me if I modeled before."*

As a result of the attention each participant received and a resultant desire for slenderness, all participants became preoccupied with food. This preoccupation usually focused on what foods to avoid as well as what foods were permissible to eat. Susan stated, *"So I started cutting out second helpings, desserts, snacks...and made a list of good and bad foods, and made an eating plan of what I was and wasn't allowed to eat."* Rachel eliminated second

helpings and snacks. She remembers, "*In home economics class I'd make promises to myself that I wasn't going to eat whatever we made.*" She states later, "*I remember making a list of good foods and bad foods.*" Rachel even took over the kitchen when she was at home so she knew what foods she would be consuming. Melissa described her obsession, "*It started as an obsession and I started to eat less every day. If I had a sandwich I'd had to have three quarters of a sandwich the next day and then half the next day.*" Later on Melissa stated, "*I love food but I also was scared of it.*"

The information above illustrates how the female adolescents who described low self-esteem prior to anorexia nervosa occurring, became consumed with the illness. The preoccupation of food, began simply to maintain a slender appearance but progressed into an obsession. The teasing from peers, that initially diminished self-esteem, was replaced with an increased attention, that the initially focused on weight loss. Yet, while the female adolescents restricted their food consumption and exercised excessively, inside they felt depressed and lonely. They portrayed a happy, content exterior while inside they felt despair.

Connections with the Family

All three participants spoke positively about their parents. In the literature, Attie and Brooks-Gunn (1989) believe that it is the family that contributes to the first ideas of self. Melissa and Rachel described how supportive their families were. Melissa stated, "*We're a close family. We*

always cuddle and everything." Rachel recalled, *" I was really protected when I was growing up...I totally loved my parents and respected them... my family is number one for sure...they are so supportive of me...my childhood - I was pretty happy. I was the delight of the family."* Susan described her family as supportive while she growing up but recounted a slightly different picture in her recovery period. She stated, "*I had always experienced my family as very loving and* ...(my parents) *were very nurturing; looking back I see a a lot of control in my family; a lot of co-dependency issues, relationship, addiction issues."* Researchers Reeves and Johnson (1992), Strigel-Moore and Connor-Greene(1991),Rastam and Gillberg (1991) Strober (1985), Garfinkel et al. (1983) and Kalucy et al. (1977) described family connections such as a lack of emotional display as a potential contributor to the development of anorexia nervosa. As well, Bruch (1978) stated that, "many anorexics express themselves in similar ways, even in much the same imagery, that their whole life had been an ordeal of wanting to live up to the expectations of their families, always fearing they were not good enough in comparison to others and therefore, disappointing failures" (p. 23). This finding relates to Rachel who stated that her parents did not provide praise nor criticism toward her accomplishments. She stated, "*My Mom and Dad never said anything about anything, because they didn't, I always thought that I had to do better to make them happy."* It is the prolongation of dependency and the intensity of parental love which contributes to the onset of anorexia nervosa in daughters, according to Brumberg (1988). Rachel described her feelings as, "*I was always*

raised by my Mom, and my Mom was really sick when I was born, so I thought it was my fault...when I look back, it was like I mothered my mother."

Connections with family impacted two of the participants. For example, Melissa and Rachel described how important their relationships are with their sister(s). Melissa expressed a desire, "*I would be tall and as pretty as my sister and then I think people would like me.*" Rachel stated, "*My two older sisters, they were my role models, and I really respected and idolized them.*"

All of the female adolescents, described a happy home life. Susan felt nurtured while growing up despite a contrasting view in recovery. Melissa spoke of how affectionate her family was. Rachel stated repeatedly how important her family was to her; throughout her recovery, she has felt their support.

Self-Mutilation and Suicide

Results that did not appear in the literature, included the themes of mutilation and suicide; for example two of the participants stated that they practiced self-mutilation. Melissa recounted during her hospital stay, "*All these kids around me were cutting their wrists...I met so many friends and all them did it so I tried. It was like an addiction, where you have to do it more.*" It was also during a hospital stay that Susan stated, "*I had done a lot of self-mutilating as well.*" As well all three participants recalled suicide ideation. Melissa recalled during her hospital stay, "*I was begging and I was like 'I'll kill myself. I swear, I'll kill myself if you do not take me home'...I just threatened.*"

Similarly, Rachel stated, "*I couldn't kill myself; I couldn't commit suicide because that would devastate my parents.*" Susan attempted suicide in grade 9. She stated, "*Although I didn't attempt suicide again, it was always there; it was always on my mind.*" By her second year at school in Toronto, Susan described her feelings, "*All I saw was blackness and again constantly thinking about suicide...I was in a more desperate mental space and I had a lot of near suicide attempts where I'd accumulate pills and such.*"

The feelings of despair and depression described earlier by each of the female adolescents, progressed to include suicidal ideation. For two of the females, the suicide thoughts were accompanied by self-mutilation. For Susan, the suicidal ideation became an attempt in Grade 9. The obsession toward slenderness progressed from self-starvation to include self-mutilation, and contemplating taking one's life.

Attempts at Recovery

As a result of their critical weight loss, all three participants were hospitalized. Their stories reveal that even though the participants did seek professional help, their personal struggle withstood their hospitalization. Even after consulting professional help, the battle with anorexia nervosa raged on. Melissa remembered, "*I got in the hospital and that was awful. I was there for two months...and it was to hard. It was so scary. I had to eat six to seven meals a day.*" Susan sought out professional help at different points in her struggle. She stated, "*I sought many psychologists, doctors,*

psychiatrists...basically tried everything that's out there currently for eating disorders." She felt the reason her efforts failed was because her thoughts in her mind never changed. She wanted to maintain her "anorexic" behaviors. At one point, Susan was told by one doctor that she would never recover. The best that she could hope for was to function and just get on with her life! Susan stated, *"They never thought I would recover. They'd come to label me as hopeless."* Finally she was hospitalized after a nine year struggle. She meet a doctor who had been an anorexic herself. Susan remembered, *"I was hospitalized immediately after meeting her."* Susan was hospitalized more than once. It was the second hospitalization that was her last. She began her recovery during this stay in the hospital. She stated, *"This time I entered the hospital knowing that what I needed to do was to surrender. I think that's the hardest thing I had to do."* Susan has been in recovery for two years.

Similar to Susan, Rachel did seek professional help early on in her illness. It was after one of her runs, that she was rushed to the hospital because she could not breathe. She recalled, *"It looked like an allergic reaction but I had diarrhea and cramping, and my tongue puffed up, and I couldn't breathe."* She also went to her doctor earlier because she had stopped menstruating. The doctor informed Rachel and her mother that only Olympic athletes lose their period from over exercising. It wasn't until Rachel and her family attended family counseling and she admitted being bulimic, that she received help. The doctor gave her family a book that both Rachel and her father read. After reading the book, Rachel felt as though her denial had

melted away. She stated, *"My denial melted away...it was like someone had followed me around this whole year."* Rachel was finally hospitalized for her illness. She remembered, *"We did find a doctor...I had collapsed one night after volleyball practice. I was admitted to the hospital that day...for three months."* Although her recovery process has not been easy for her, Rachel has been in recovery for one year.

For Susan and Rachel, it was not the hospital that contributed to their recovery but the doctor they found, who her self had been an Anorexic. Both of them are devoted to their recovery. Melissa continues to struggle with anorexia nervosa.

Discussion of Results Related to Personal Experience

The results of this study parallel my personal experiences. Prior to my development of anorexia, I recall people commenting on how confident I appeared. Little did they know, appearance was the operative word. For several years I always felt inadequate amongst my peers. It was not until I began weight training and believed in my own abilities did that perception change. I do not recall if the comments made by people about weight loss spurned my weight loss. I do recall a feeling of satisfaction every time I selected a weight to achieve and did just that. I also recall how elated I felt when my clothes began to feel looser on me.

Susan and Rachel stated that teasing in their younger years provided a feeling of inadequacy. I, too, was teased by my family in a fun way and by my

peers. The teasing by both seemed to hurt even though one was done in jest and the other was done with intent. I do recall, similar to Rachel, a feeling of never being quite good enough for my family. My family never stated exactly those words, but through other words and comments I did have an interpretation that I was not quite making the grade. I do recall, similar to all three participants, feelings of depression and unhappiness during my struggle. I remember feeling as though I was fighting the world. No one understood my inner turmoil; at times, I did not either. Similar to Melissa, Susan and Rachel I recall being preoccupied with food, usually food to avoid. I became an expert on calories in each food item. I too, was also hospitalized due to my low weight and I found the psychiatric ward a futile waste of time for overcoming my battle.

My struggle with anorexia nervosa was over ten years ago. I remember the decision I made, to conquer anorexia's hold on my life. I decided that there were other things I wanted more in my life, then the everyday struggle with anorexia nervosa. Each person's point of transition is different. For Susan, the decision took her over nine years to make. Rachel's decision came about as a result of discovering that she was suffering but she was not alone. The book she read melted away her denial, and gave her the ambition to resolve her struggle. For Melissa, the battle with anorexia nervosa continues.

Implications for Further Research

This current research identified additional areas of research that should be addressed. The data set for this study was limited. A replication of this study, with a larger sample could be completed. The larger sample would have more stories and perhaps different themes would emerge as well as similar themes to the findings in this study. Although this study focused on adolescent females, anorexia nervosa is not confined to that aggregate. It would be interesting to interview females who developed anorexia post-adolescence, to identify what precursors contnbuted to the development of their illness. Population groups, for example, could include young women between 20-30 years and 45-65 years. A comparison between these two groups could identify different factors that influenced the development of the illness.

Comparing the findings from a control and experimental group within the same setting, such as, the same school, could be another study. The control group would be young female adolescents diagnosed with anorexia nervosa while the experimental group would be female adolescents not diagnosed with anorexia nervosa. The study might further identify what factors contribute to the development of the illness.

Interviewing family members of the anorexic, could present a different perspective on the illness. For example, the siblings and parents of anorexics could be interviewed to see how they perceived the family milieu. This data would provide additional information about the connections with the family related to the development of anorexia nervosa.

Another area for further research, could be an investigation of the relationship between teasing and the development of anorexia nervosa. In this study, Susan and Rachel, cited that they were teased in their earlier years, predominately by their peers. Susan stated that she believed that teasing exacerbated her illness. However, it is unclear how teasing contributed directly to the development of anorexia. Although, it would be difficult to interview the identified peer group, it would be valuable to learn if they perceived their teasing as detrimental. A larger sample population would provide further information clarifying the relationship between teasing andthe development of anorexia nervosa.

Another area of research could expand the sample to include those female adolescents whoa are involved in elite sports and professional dancers. For example, in this study Susan was a ballet dancer but stated that she felt that she would have been anorexic regardless of the ballet. A study within this genera could present a transformation that showed the development of a professional dancer or a elite athlete and the pressures she encountered from others including dance instructors/coaches, peers, parents. The study could identify what role, if any, the world of ballet contributed to the development of anorexia nervosa.

Another study could be those females with high scholastic achievement, since high achievement was stated by Susan and Rachel in this study. The study could identify the connection, if any, between the strive for slenderness in anorexia nervosa and high scholastic achievement.

Although eating disorders have usually been associated with upper class females, Rand and Kuldau (1992) found that lower economic class and older women are becoming part of the population segment of people with eating disorders. Therefore, a study that did not restrict participants to a certain economic class, could pursue those findings.

One final area for further research could focus on the transition of becoming an anorexic as well as the transition into recovery. The study would further document the emotional transition that carries a person into the world of an eating disorder, and then what transpires emotionally to transfer the individual out of the struggle. It would focus on the emotional impact the illness has on the individual, and how the illness contributes to the desire to enter recovery.

There are likely additional ideas regarding the development of anorexia nervosa that are not listed above that could be studied. The reason for the development of anorexia nervosa has to be uncovered in order to begin focusing programs on the prevention of the illness.

Chapter Seven

Summary

This research began as a quest to answer questions about a portion of my past, that influenced the person I have become. I sought to understand, why, at the age of seventeen, I began a pursuit with dieting, that eventually spiraled out of control. I had not heard of anorexia nervosa prior to my struggle with it. Once I was diagnosed with anorexia nervosa, I was unclear as to what the diagnosis meant. Although my struggle ended over ten years ago, the mystery surrounding the circumstances of anorexia entering my life, remained.

With a desire to answer some questions from my past, my research question evolved. The purpose of this study became to collect stories from female adolescents who were or had experienced anorexia nervosa, to understand why the illness develops. By collecting other female adolescent stories, I felt similarities would emerge. The similarities in the stories would divulge the reason why young females begin such a terrifying struggle. The research is complete, and the question remains unanswered. The findings did reveal some similarities in the themes that emerged from the stories. For example, the feeling of not being recognized by the popular adolescents, left each of the females feeling they did not belong. The feeling was described by Rachel as being on the fringe of the popular crowd. However, with the advent of weight loss, a more slender appearance resulted in an increased attention from others. The individuals that were once unnoticed by the peer group were now embraced. The increased attention was, in their minds, related to the

weight loss they achieved. Therefore, in order to maintain the attention and perceived approval from the peer group, the females believed that they had to maintain the slender appearance - at any cost. The cost was their health and possibly their life. As food restrictions increased, the amount of food consumed decreased. As the fear of weight gain persisted, the amount of exercise escalated. The irony became, the sense of belonging by the peer group that was once sought after and treasured, lost its importance. Any spare time was devoted to exercise. Thoughts centered around the fear that food could potentially cause weight gain and life became a complete determination toward achieving slenderness. Yet, the goal was perceived to be consistently out of reach and the amount of weight loss was never enough. The adolescents described a feeling of depression and despair throughout their struggle.

Two of the participants in this study, described the difficulty of releasing anorexia from its hold on their lives. For example, Susan acknowledged that other people required nourishment, but she was different. If she consumed the same food, she would become overweight. The attention that all participants received from their peers, reinforced the societal perceptions that slenderness is valued. Melissa would exercise when her mother was in the bathroom, to avoid being caught. Rachel recounted retreating to the basement to do her aerobics, but also to engage in purging herself as well. Both Rachel and Susan excused the increase in their exercise regime as a necessary part of their "training". The consistent secrecy behind the exercise must have indicated to them that the behavior was not correct or healthy.

Despite the information contained in the participants stories, the reason

why anorexia nervosa develops remains unclear. All three participants described slightly different reasons for pursuing their struggle. For Rachel and Melissa, the weight loss was inadvertently obtained, initially. For Susan however, there was a conscious decision to avoid becoming overweight based on comments from her mother. The comment that the boys will not like you if you are fat, speaks to the societal ideal that slenderness is valued. At extreme limits however, it could be argued that slenderness is also impossible and unhealthy.

There does appear to be a transition for individuals when they enter the world of anorexia nervosa. Initially, it is not the weight loss that is the motivator. The weight loss becomes the overt sign that the individual is engaged in a struggle. Yet, at the onset, the weight loss is recognized and applauded as an accomplishment. It is the events that preclude the transition that remain unclear. For Susan and Rachel, there was a second transition, into recovery. Susan described a feeling of having hit rock bottom, a feeling that she was going to die if she did not seek professional help. Rachel, however, mentioned the realization that she was not alone in her struggle and that there was help available. She would just have to locate it. Similar to the transition into the world of anorexia nervosa, the reason to exit the world remains unclear.

As a researcher in this field, what I find confusing is that the illness is not new. It did not appear with the popularity of *Twiggy* in the 1960's nor the popularity of plastic surgery to correct imperfections in the 1980's. The illness has been around since the 13th and 15th century. What is concerning is the

increase in the prevalence rate, without an increase in the understanding why anorexia nervosa develops. The literature remains virtually unchanged over the past twenty years. The medical profession has not discovered a proven treatment that heralds a success. There are other treatment facilities emerging that present false hopes to suffers and family alike. One in particular, charges elaborate fees for no guarantees of recovery. The illness remains a mystery. No one has uncovered why it develops.

Within the health care realm, I think that there is a need for further research in the area of anorexia nervosa to understand why it develops. It is only when understanding is achieved, can the focus shift toward education and prevention. Currently, there is a shift in the medical establishment away from a reactive philosophy, that focuses on treatment, to a proactive approach of prevention. It is my perception that anorexia nervosa cannot be preventedfrom occurring if we do not understand why it develops. Meanwhile, we within the health care realm, can promote self-acceptance, regardless of shape or size. We can follow a Health Promotion perspective and educate individuals how to develop a sense of self-worth and value regardless of class, race, size or shape. The pursuit towards an "ideal" figure that is unobtainable for the majority, and unhealthy for those that are able to achieve it, needs to cease.

A man is rich according to what he is, not according to what he has.

The above saying was on a card I gave my father years ago. Health Promotion professionals need to promote the value of one another based on who we are and not an established a criteria to judge one another. Josselson

(1995) states that it is only by investigating the complex nature of human meaning that we can approach the understanding of people. We need to understand why individuals begin their struggle with anorexia nervosa. The obsession with slenderness, has to be diverted into something more positive.

The interviews I conducted with each of the participants, were very difficult for me. I was not anticipating the magnitude of emotional response that I felt. "It is virtually impossible to imagine having an experience that does not carry with it emotional, moral and aesthetic content (Connelly and Clandinin, 1988, p. 26). I hope that my efforts to bring understanding about individuals' struggle with anorexia nervosa will begin research in the area of understanding why anorexia develops. Although this study did not uncover conclusively why anorexia develops, I believe the stories contain a great deal of valuable information for future research.

God grant me the Serenity

to accept the things I cannot change

the Courage to change

the things I can

and the Wisdom to know

the difference.

I hope that my courage to change the focus of research in the field of anorexia nervosa is only the beginning and the journey toward increased understanding has begun with this small yet important step.

APPENDIX A

Interview Questions

Grand tour:

Describe the events surrounding the period when you began dieting and how you felt.

Other questions that may be asked:

- Describe the point when you felt you moved beyond casual dieting and how you felt.
- How would you describe yourself in school?
- How would you describe yourself in reference to your other family members?
- Describe you childhood.
- Describe your family.
- What obstacle, if any, do you consider present in you life now? When you began dieting?
- Describe your feelings toward yourself now? Before you started dieting? What, if anything, would you change?
- Describe your feeling when you were informed of your diagnosis of anorexia nervosa.
- How would you currently describe yourself?
- How would your parents describe you?
- How would your peer group describe you?

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